IMPORTANT INSTRUCTIONS: Prior to submitting this form, all persons requesting coverage must review the important disclosures and information found on www.unuminfo.com/costco or in a paper enrollment kit. You can request a paper enrollment kit by calling 1-800-227-4165. DO NOT submit this form if you have not reviewed those materials.

Underwritten by:
Unum Life Insurance Co of America
LTC Department
2211 Congress Street
Portland, Maine 04122

COSTCO WHOLESALE CORPORATION
Benefit Election Form
Long Term Care - Policy #543523

Your Name: (Last Name, First, Middle Initial)	Social Security Number __ __ __ - __ __ - __ __ __ __	Date of Birth (MM/DD/YYYY) __ __/__ __/__ __ __ __
Street Address	Gender ☐ Male ☐ Female	Date of Hire (MM/DD/YYYY) __ __/__ __/__ __ __ __
City, State, Zip Code	Home Telephone # ( )	Work Telephone # ( )
Applicant's Email Address:		

Complete the following only if applicant is not the employee

Employee's Name	Employee Social Security No. __ __ __ - __ __ - __ __ __ __	Employee Date of Birth __ __/__ __/__ __ __ __	Employee Date of Hire __ __/__ __/__ __ __ __

Applicant Is: (This Benefit Election Form must be completed for any selection)

☐ Previous Employee	
☐ Employee's Parent or Grandparent	☐ Sibling *(minimum age 18)*
☐ Spouse's / Domestic Partner's Parent or Grandparent	☐ Child *(minimum age 18)*

Plans

(Check one)	☐ **Plan 1**	☐ **Plan 2**
	• Long Term Care Facility • Simple Inflation • Professional Home Care	• Long Term Care Facility • Simple Inflation • Professional Home Care • Total Home Care

Facility Monthly Benefit Amount

(Check one)	☐ $1,000	☐ $2,000	☐ $3,000	☐ $4,000	☐ $5,000	☐ $6,000

Facility Benefit Duration ***(Duration of benefits may vary depending on where benefits are received.)***

(Check one)	☐ 3 Years	☐ 6 Years

ALL FAMILY MEMBERS: The Long Term Care Application (medical questionnaire), the Benefit Election form and a signed Authorization to request Medical Information Form #6720-03 located in the enrollment kit, must be completed and you must be approved for coverage in order to enroll in the Long Term Care plan.

Form is Continued on Reverse Side

Calculate your Premium:

_____	X	_____	÷	$1,000	=	_____
Rate for plan chosen		Facility Monthly Benefit Amount				Your Premium

Eligible Family Members: Please select payment method: ☐ Monthly Automatic Payments (deducted from your checking account – complete Authorization/Agreement for Automatic Payments), **OR**

Billed directly (paper) by the insurance company: ☐ Quarterly ☐ Semi-Annually ☐ Annually

Caution: If your answers on this Enrollment Form are incorrect or untrue, we may have the right to deny benefits or rescind your insurance.

By signing below, you signify that you have read and understand that loss of Activities of Daily Living (ADL) or Severe Cognitive Impairment must occur after your effective date of coverage under this Long Term Care plan in order to be covered, and that certain limitations and exclusions apply to your coverage.

You also acknowledge that you have received the **Potential Rate Increase Disclosure Form** and **Personal Worksheet.**

_____	__ __/__ __/__ __ __ __	_____	__ __/__ __/__ __ __ __
Applicant's Signature	*Date*	*Employee's Signature*	*Date*

All applicants, sign and mail all required signature forms to Unum (address at top of page).
Retain a copy for your records. (M5)

If you have questions about Long Term Care coverage, please call Unum's toll-free number: 1-877-403-9348 (Option 3).